STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455819	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Heights Health and Rehabilitation Center	4825 Wellesley St Fort Worth, TX 76107

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plans for 3 (Residents #1, #2, and #3) of 5 residents reviewed for comprehensive care plans in that: The MDS Coordinators failed to individualize the care plans, to include interventions, for Residents #1, #2, and #3. This failure could place the residents at risk of receiving the individualized care they required. Findings included: Review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included fracture of right lower leg. morbid obesity, heart failure, and asthma. Review of Resident #1's admission MDS assessment, dated 01/04/24, revealed a BIMS score of 10 indicating she had mild cognitive impairment. Her Functional Status indicated she required assistance with most of her ADLs. Review of Resident #1's care plan, dated 01/01/24 revealed her care plan had not been individualized. Resident #1 has a rash (specify location, type, and extent) r/t; The resident is risk for falls r/t; and The resident has potential fluid deficit r/t. The majority of Resident #1's Focuses as well as Interventions had not been individualized. Review of Resident #2's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included open wound to scalp post cancer surgery, heart disease, and high blood pressure. Review of Resident #2's admission MDS assessment, dated 02/18/24, revealed a BIMS score of 13, indicating he was cognitively intact. His Functional Status indicated he was independent in most of his ADLs except eating and hygiene. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's care plan, dated 02/16/24, revealed his care plan had not been individualized. Resident #2 has a pacemaker (specify type) r/t; The resident is at risk for falls r/t; and The resident has hypertension r/t. The majority of Resident #2's Focuses and Interventions had not been individualized. Review of Resident #3's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia, diabetes, and alcoholic liver disease. Review of Resident #3's admission MDS assessment, dated 02/15/24, revealed a BIMS score of 9 indicating he had moderate cognitive impairment. His Functional Status indicated he required minimal assistance with his ADLs. Review of Resident #3's care plan, dated 02/09/24, revealed his care plan had not been individualized. Resident #3 is at risk for falls r/t; The resident has a communication problem r/t; and The resident has potential fluid deficit r/t. The rest of Resident #3's Focuses and Interventions had not been individualized. Interview on 04/04/24 at 3:00 PM with the MDS Coordinator revealed she had been in her position since August 2023. She stated when she and the other Coordinator took over the roles the MDSs, care plans, and PASRR were all a mess. She stated the two of them had been trying to catch things up. The MDS Coordinator stated care plans should all be individualized to each resident. She stated the DON or the ADON enter the baseline care plan which triggers alerts in the comprehensive care plan. The MDS Coordinators were then responsible for completing the comprehensive care plan after they completed the MDS. The MDS Coordinators stated Residents #1, #2, and #3 were all being worked on, but had not been completed. Interview on 04/04/24 at 3:11 PM with the DON revealed each department (Dietary, Rehabilitation, etc .) add their part of the care plan, and the MDS Coordinators were responsible for keeping them updated with information provided during the morning meetings. The DON stated the risk to residents to not have individualized care plans, staff might not know what care the resident needed. The DON stated she was ultimately responsible for everything in the facility including MDS and care plans, but she relied on everyone doing their job properly. There was no true oversight of each department. Review of the facility's current, undated Comprehensive Care Planning policy reflected: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his preferences and goals.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living, receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Resident #1) of 3 residents reviewed for ADLs. The facility failed to ensure Resident #1 was not left in a soiled brief for an extended period of time on 04/04/24. This failure could place the resident at risk for skin breakdown. Findings included: Review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included fracture of right lower leg, morbid obesity, heart failure, and asthma. Review of Resident #1's admission MDS assessment, dated 01/04/24, revealed a BIMS score of 10 indicating she was mildly cognitively impaired. Her Functional Status indicated she required assistance with most of her ADLs, and assistance of 1-2 people for toileting. Her Bowel and Bladder Assessment indicated she was always incontinent of bowel. Review of Resident #1's care plan, dated 01/01/24 revealed her care plan had not been individualized. Resident #1 was a risk for pressure ulcer development, the resident had a skin tear, laceration or abrasions to. The resident has a surgical site to:The resident has an ADL Self Care Performance Deficit. Resident #1 was not care planned for bowel and bladder incontinence. Observation and interview on 04/04/24 at 9:05 AM Resident #1 stated she was currently soiled, and she had called for help at 8:40 AM. The resident had times and dates documented on her cell phone and showed them to the surveyor. Resident #1 stated CNA A had answered the call light within a few minutes and stated she was going to find help. CNA A was observed to have returned with the Staffing Coordinator at 9:26 AM to perform incontinence care. Resident #1 stated it was the second time that morning she had to wait and extended period of time to be changed. She stated she pushed the call light at 6:18 AM and CNA B answered at 6:59 AM, CNA B went for help, and she was finally changed at 7:18 AM. Resident #1 stated she has had to call her family at home to come help her get changed because staff had not responded or there was not enough help for two people to come in and help. Resident #1 stated she felt like she had developed skin breakdown because of lying in her waste for long periods of time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Arlington Heights Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4825 Wellesley St Fort Worth, TX 76107	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/04/24 at 9:20 AM with Resident #1's family member revealed they had been called at home multiple times by the resident when she was not getting the help she needed. They stated often they would come in to help with incontinence care only to observe the nurse sitting at the nurse station not doing anything. and the CNA and he would change the resident. The family member stated they stay at the facility most of the day every day to assist with care because there is never enough staff to give prompt care. The CNAs always had to look for someone to help them, so he ended up assisting the CNA. The family member stated they knew they would be helping the resident when she went home, but he did not think he should have to be so involved while she was still at the facility. Observation on 04/04/24 at 1:07 PM of incontinence care provided by CNA B and the family member revealed the resident had soft stool. CNA B provided the resident with perineal care, while the family member held the resident up. The resident had reddened areas in the skin folds on both sides of her perineal area, and barrier cream was applied, The resident had reddened areas to both buttocks, also treated with barrier cream. No skin breakdown was observed. Interview on 04/04/24 at 1:35 PM with the ADON revealed stated his expectation for call light response was for it to be answered within 5-15 minutes. He stated anything longer than that would be unacceptable depending on what else was going on in the unit. The ADON stated a 45-minute response time was definitely excessive. The staff should answer the call light. If help was needed,they should be able to find someone to help within 5-10 minutes. If it was taking longer than that they needed to update the resident to let them know they had not been forgotten. Interview on 04/04/24 at 1:40 PM with the DON revealed she expected call lights to be answered within 5-10 minutes depending on what was going on in the hall. The DON stated if a CNA needed help with a resident, they should be able to find someone within 10-20 minutes. She stated they had no staffing shortages, all open positions were covered by staff. The DON stated she was unaware that Resident #1's family was being called at home to come help with the resident. She stated the family needed to learn to care for the resident as she was due to be discharged in a few days, so it was good training. Interview on 04/04/24 at 2:00 PM with CNA A revealed the incontinence care for Resident #1 at 9:30 AM was delayed because she could not find any help. CNA A stated the other CNA was out monitoring the smoking residents, she could not find the nurse, she asked for help on the 200 hall, and finally asked the Staffing Coordinator to help her. CNA A stated leaving the resident in soiled briefs for extended periods could cause skin breakdown. Interview on 04/04/24 at 2:10 PM with CNA B revealed she had been out with the smokers from 9:00 AM-9:30 AM. CNA B stated they often used the help of Resident #1's family because they could not find the other CNA, and the nurses usually would not help because they had something else to do. CNA B stated the risk of leaving a resident in soiled briefs was that it could cause skin breakdown or urinary tract infections. Interview on 04/04/24 at 2:15 PM with the Staffing Coordinator revealed CNA A came to her for help because she could not find any help for Resident #1. The Staffing Coordinator stated it was rare for the CNAs to have to come to her for help. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's current Perineal Care Female policy, dated 12/08/09, reflected the steps of providing care, but did not reference time frames for care or define what would be considered prolonged wait times.